RHRA Retirement Homes Regulatory Authority

FINAL INSPECTION REPORT
Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: June 23, 2015	**Name of Inspector:** Debbie Rydall
Inspection Type: Routine Inspection	
Licensee: 2259976 Ontario Inc. / 1685 Third Avenue, Owen Sound, ON N4K 4R3 (the "Licensee")	
Retirement Home: Kelso Pines Retirement Home / 1685 3rd Avenue, Owen Sound, ON N4K 4R3 (the "home")	
Licence Number: S0105	

Purpose of Inspection
The RHRA conducts routine inspections as set out in section 77(3) of the *Retirement Homes Act, 2010* (the "RHA").

NON-COMPLIANCE
1. The Licensee failed to comply with O. Reg. 166/11, s. 25; Emergency plan, retirement home with more than 10 residents. Specifically, the Licensee failed to comply with the following subsection(s): **25. (3)** The licensee shall ensure that the emergency plan provides for the following: 2. Evacuation of the retirement home, including a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency. 3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the retirement home and regular testing of all such resources, supplies and equipment to ensure that they are in working order. 4. Identification of the community agencies, partner facilities and resources that will be involved in responding to an emergency. **25. (4)** The licensee shall ensure that the emergency plan addresses the following components: 4. Specific staff roles and responsibilities.
Inspection Finding The home has a written emergency plan in place; however the plan is not completely aligned to the requirements of the legislation.
Outcome Corrective action taken by the Licensee.

2. The Licensee failed to comply with O. Reg. 166/11, s. 29; Administration of drugs or other substances.
The Licensee failed to comply with O. Reg. 166/11, s. 30; Storage of drugs or other substances.
The Licensee failed to comply with O. Reg. 166/11, s. 31; Medication management system.
The Licensee failed to comply with O. Reg. 166/11, s. 32; Records.

Specifically, the Licensee failed to comply with the following subsection(s):

29. If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall ensure that,

(c) neither the licensee nor a staff member administers a drug to a resident in the home unless the licensee or the staff member has received training in the procedures applicable to the administration of the drug;

30. If drugs or other substances are stored in a retirement home on behalf of a resident, the licensee of the home shall ensure that,

(b) controlled substances as defined in the Controlled Drugs and Substances Act (Canada) are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart;

31. (1) If one of the care services that the licensee or the staff of a retirement home provide to a resident of the home is the administration of a drug or other substance, the licensee shall establish a medication management system, which includes written policies and procedures, to ensure that all drugs and other substances to be administered to residents of the home are acquired, received in the home, stored, dispensed, administered, destroyed and disposed of correctly as required by law and in accordance with prevailing practices.

32. If the licensee or a member of the staff of a retirement home administers a drug or other substance to a resident, the licensee shall ensure that,

(b) if a drug is administered, there is written evidence that the drug was prescribed for the resident by a person who is authorized to prescribe a drug under section 27 of the Regulated Health Professions Act, 1991;

Inspection Finding

The inspection revealed that the written medication management system was not aligned with the different types of systems and practices in place in the home and did not address how medications from other pharmacies were acquired, received, stored, administered, destroyed and disposed of correctly. There was evidence to support that not all staff administering medications had received the required training in medication administration. There was no evidence provided at the time of the inspection to support that orders were in place for the stock medications in use in the home. Controlled substances were secured in the medication cart but were not all double locked as is required by the legislation.

Outcome

Corrective action scheduled to be completed by the Licensee by August 10, 2015.

NOTICE

The Final Inspection Report is being provided to the Licensee, the Registrar of the Retirement Homes Regulatory Authority (the "RHRA") and the home's Residents' Council, if any.

Section 55 of the RHA requires that the Final Inspection Report be posted in the home in a conspicuous and easily accessible location. In addition, the Licensee must ensure that copies of every Final Inspection Report from the previous two (2) years are made available in the Home, in an easily accessible location.

The Registrar's copy of the Final Inspection Report, as it appears here, will be included on the RHRA Public Register, available online at http://rhra.ca/en/register/

Signature of Inspector	Date
	July 29, 2015